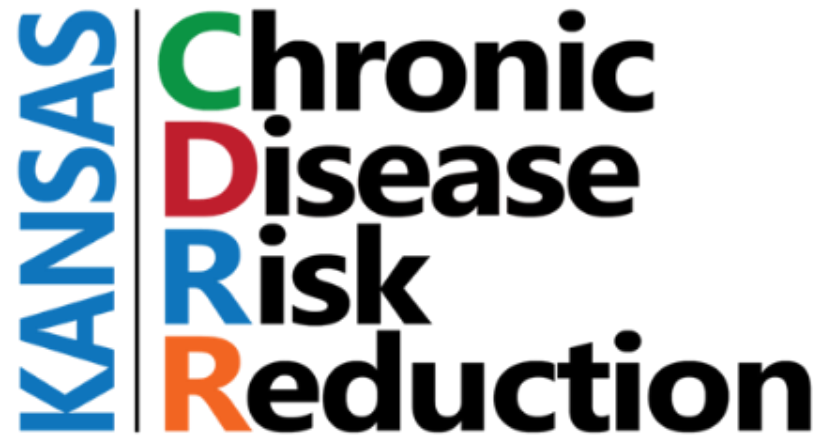


CDRR 101

Welcome and
Overview

Application
Instructions

Q and A



Goal 1

Goal 2

Goal 3

Goal 4

Goal 5



Community Health Promotion Section



3 Risk Factors

```
graph TD; A[3 Risk Factors] --> B[Contribute to 4 chronic diseases]; B --> C[Which, in turn, contribute to approximately 80% of all deaths in the United States];
```

- Tobacco use
- Poor diet/nutrition
- Physical inactivity

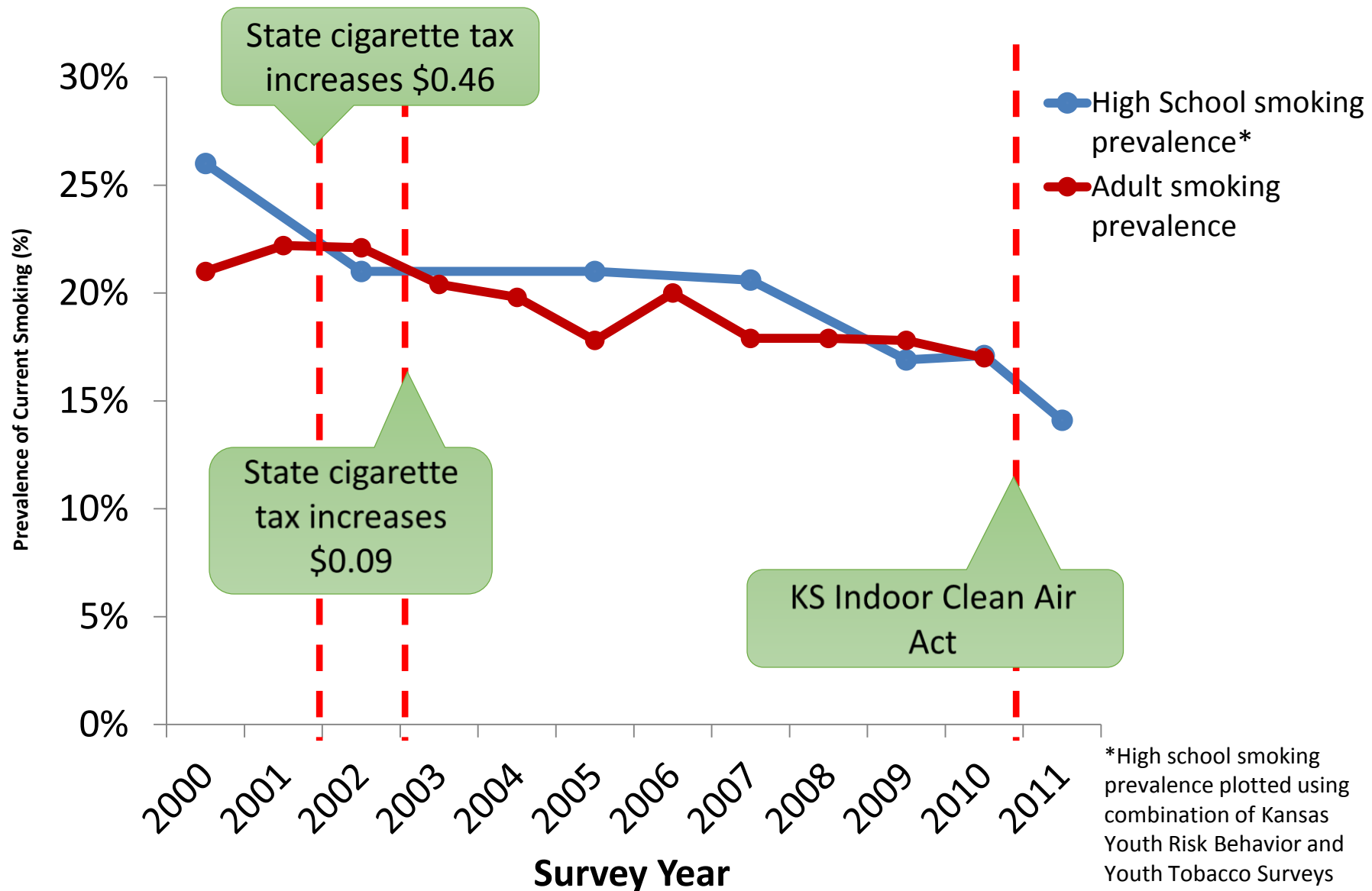
3-FOUR-80

Contribute to **FOUR** chronic diseases

- Heart disease
- Type 2 diabetes
- Lung disease
- Some cancers

Which, in turn, contribute to approximately **80%** of all deaths in the United States

Current Smoking Prevalence Among Kansas Adults and Kansas High School Students - YTS, YRBS & BRFSS, 2000-2011

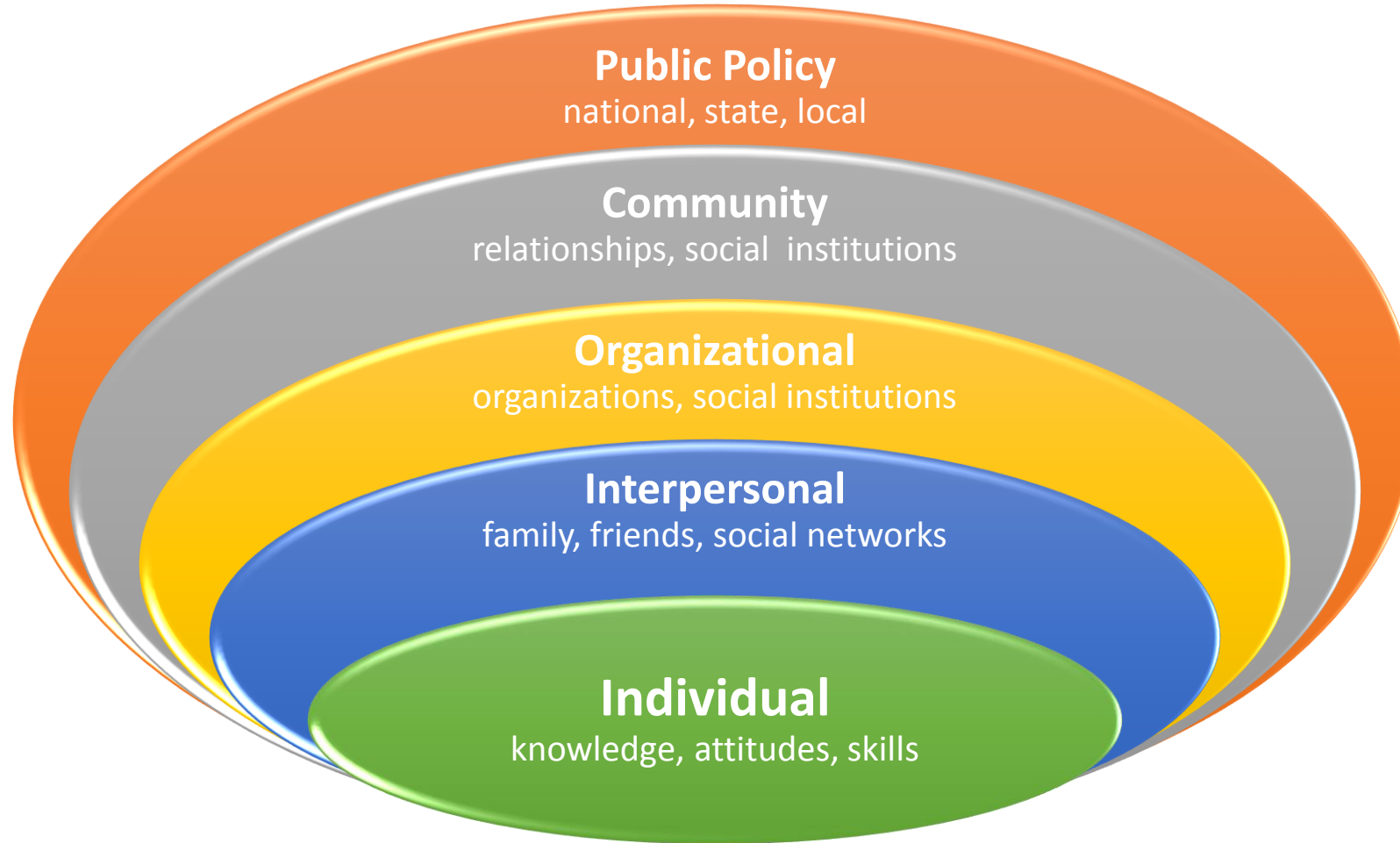


*High school smoking prevalence plotted using combination of Kansas Youth Risk Behavior and Youth Tobacco Surveys

Source: High school smoking prevalence – Youth Tobacco Survey (KDHE) and Youth Risk Behavior Survey (KSDE)
Adult smoking prevalence – Behavioral Risk Factor Surveillance System (KDHE)

Establishing a Strong Foundation

The Socio-Ecological Model



Building the Base to Support CDRR

Time Period	Program Name	Focus	KDHE Base Funding Source
1980's	LIVELY	Disease management	\$150,800- block grant
1991	CVH	PANT	\$150,800- block grant
1992	CDRR	PANT	\$150,800- block grant + Kansas LEAN
1994	CDRR	PANT	\$150,800- block grant + Kansas LEAN (schools) + Federal TUPP Funds
2000-2002	CDRR	PANT	\$150,800- block grant + Federal TUPP Funds + CIF
2015	CDRR	PANT	\$150,800- block grant + Federal TUPP funds + CIF + 1305 funds
2016-18	CDRR	PANT+ CDMSE	\$325,000- block grant + Federal TUPP funds + CIF + 1305 funds

Priority Goal Areas

- **Goal 1:** Prevent initiation of tobacco use among young people
- **Goal 2:** Eliminate nonsmokers' exposure to secondhand smoke
- **Goal 3:** Promote quitting among adults and young people
- **Goal 4:** Increase physical activity, access to healthy foods, and community resiliency
- **Goal 5:** Increase the ability of those with chronic disease to manage their condition(s)



Welcome and Overview

- Introductions
- Q and A—use note cards to write down your questions
- Mission of CDRR:

Promote Healthy Communities through policies, systems and environmental changes that support and promote:

- ❖ Tobacco use prevention and dependence treatment
- ❖ Access to healthy foods and physical activity opportunities
- ❖ Chronic disease management

What's New for FY18?

- Increase accountability for addressing health equity, targeting efforts
- Goal 3 – Tobacco Cessation
 - Behavioral health and tobacco use
 - Pregnancy and tobacco use
 - FQHC's
- Goal 4 - Physical Activity and Nutrition – Community Resilience



Kansas Tobacco Control Strategic Plan, 2016 – 2020

Vision: A healthy, tobacco-free Kansas

Mission: Prevent and eliminate tobacco use among Kansans of all ages through advocacy, education, and collaboration

Priority Audiences

- Low income adults
- Adults with poor mental health status
- Pregnant women
- Youth and young adults

Goals <i>Focus on</i>	PREVENT TOBACCO USE	SECONDHAND SMOKE	TOBACCO CESSATION	DISPARITIES
Objectives <i>Measure</i>	1. Prevent initiation among youth and young adults 1.1. Reduce the percentage of high school students who use cigarettes, e-cigarettes and any tobacco products respectively by 5 percentage points. 1.2. Reduce the percentage of 18-24 year olds who use cigarettes, e-cigarettes and any tobacco products respectively by 5 percentage points.	2. Eliminate exposure to secondhand smoke 2.1. Decrease the percentage of high school students exposed to secondhand smoke in any indoor or outdoor public place from 36.6% to 25%. 2.2. Decrease the percentage of Kansas workers who were exposed to secondhand smoke at work in the past week from 20.2% to 17%. 2.3. Decrease the percentage of Kansas adults who live in households where smoking is allowed from 13% to 8%.	3. Promote quitting among adults and youth 3.1. Increase the percentage of current smokers who make a quit attempt from 58.6% to 65.0%. 3.2. Decrease the percentage of pregnant women who smoke from 12.0% to 9.0%.	4. Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco 4.1. Reduce percentage of low income adults who smoke from 31.1% to 26%. 4.2. Decrease percentage of adults with poor mental health status who smoke from 36.1% to 31%.
Strategies <i>Work on</i>	1.1.1. / 1.2.2. Support efforts to adopt and implement evidence-based pricing strategies that discourage tobacco use 1.1.2. Support zoning and licensing policies to restrict youth access to tobacco products in the retail environment 1.1.3. Incorporate e-cigarettes in all smoke-free and tobacco-free policies at the state and local levels 1.1.4. Develop tobacco-free policies that include e-cigarettes on K-12 school properties 1.1.5. Develop and implement a large scale, counter marketing communication campaign to promote tobacco use prevention and control 1.2.2. Support the adoption and implementation of Tobacco 21 policies 1.2.3. Develop tobacco-free policies that include e-cigarettes on educational campuses, worksites or other places where 18-24 year olds are exposed to tobacco use	2.1.1. Implement policies for smoke-free parks, recreation and sports areas, campuses, and outdoor work areas 2.2.1. Close loopholes in Kansas Indoor Clean Air Act regarding exemptions for casinos, cigar bars, fraternal organizations, etc. 2.2.2. Implement tobacco-free policies and cessation support in low wage worksites and worksites in locations serving low socioeconomic status (SES) communities and racial and ethnic subgroups 2.3.1. Implement smoke-free multi-unit housing policies	3.1.1. Implement comprehensive tobacco cessation programs and treatment protocols in mental health 3.1.2. Promote increased utilization of tobacco cessation treatment available through Medicaid 3.1.3. Develop and implement a large scale, counter marketing communication campaign to promote tobacco cessation 3.1.4. Establish comprehensive insurance coverage for cessation to reduce barriers to receiving cessation benefits 3.1.5. Engage providers throughout health care systems in integrating cessation into healthcare practices 3.2.1. Educate healthcare providers on evidence-based best practices for cessation before, during, and after pregnancy 3.2.2. Implement comprehensive tobacco cessation programs and treatment protocols in prenatal and perinatal care settings 3.2.3. Increase utilization of available tobacco cessation treatment among pregnant women	4.1.1. Promote quit attempts among low-income smokers 4.1.2. Support efforts to reduce tobacco industry targeted marketing in the retail environment 4.1.3. Implement tobacco-free policies and cessation support in low wage worksites and organizations serving low SES communities and racial and ethnic subgroups. 4.1.4. Improve the availability, accessibility, and effectiveness of cessation services for populations affected by tobacco-related disparities 4.2.1. Implement policies for tobacco-free treatment in behavioral health care facilities 4.2.2. Adopt statewide regulation requiring tobacco-free grounds policies for behavioral health organizations 4.2.3. Improve the availability, accessibility, and effectiveness of cessation services in behavioral health populations

Planning/Capacity and Implementation Phases

- Planning Phase
 - Apply for a Planning/Capacity Phase if:
 - Community has not completed a health assessment within past 5 years
 - Community does not have an active coalition focused on community health
 - Planning phase grants must include a staffing plan for at least 0.25 FTE and 25% match
- Implementation Phase
 - Community has an active coalition and a current community health assessment
- Both phases must maintain a coalition or sub-committee focused on tobacco use prevention

Wyandotte County Community Health Assessment

MAKE YOUR VOICE HEARD!


We know Wyandotte County residents fill out a lot of surveys, and you want to see results. What we hear from you will be used to create a plan to make a healthier Wyandotte County.

We've been working to make the community healthier, and it's time to check in with the people who matter – those who live here!

We want to hear how *you* feel about health in your community.







We are asking you to contribute to a Wyandotte County Community Health Assessment.

This assessment is being done by the UG Public Health Department, from Wyandotte County and for Wyandotte County.



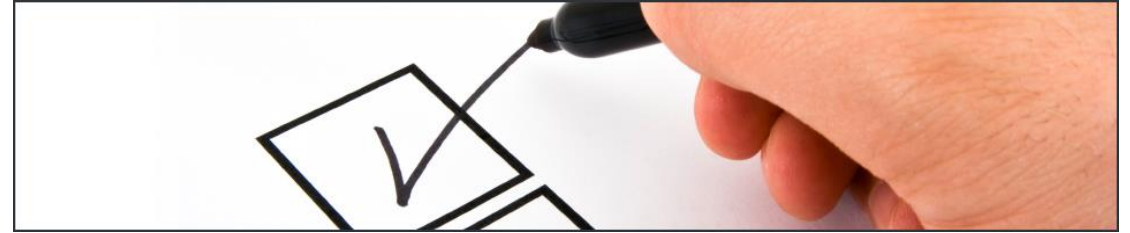
Sign up to receive a copy of the results of this survey!

Contact Joanna Sabally at the UG Health Department to learn more
jsabally@wycokck.org or 913-573-6733.



Grant Requirements and Eligibility

- Grant Requirements
 - Administration and Management
 - Data and Information Activities
 - Communications and Promotion Activities
 - Partnership Activities
- Eligibility
- Match



Public Health
Prevent. Promote. Protect.

KANSAS | Chronic
Disease
Risk
Reduction

Eligible Expenses

- Salary
- Travel
- Professional development costs
- Supplies
- Advertising, signage
- Consultants, contractors
- Facility, equipment rental
- Speaker fees
- Educational materials



Ineligible Expenses

- Food (e.g. meals, snacks for meetings)
- Direct services (e.g. tobacco cessation counseling)
- Medications
- Lobbying
- Incentives
- Capital equipment/infrastructure



Match

- 25% match required for every dollar awarded
- Examples of match:
 - Other grants that support/complement/supplement workplan
 - In-kind staff time
 - Food provided by local organizations for meetings





The Kansas Department of Health and Environment presents:
**Addressing Tobacco Use in Kansas:
 The Brief Tobacco Intervention**

Free
online
training!



In this online training, you will...

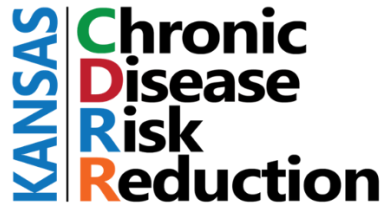
- ✓ Learn how to effectively talk with your patients about tobacco in less than 3 minutes.
- ✓ Learn about the free, state-of-the-art tobacco cessation service called the Kansas Tobacco Quitline.

To view the training, visit...

www.kstobaccointervention.org



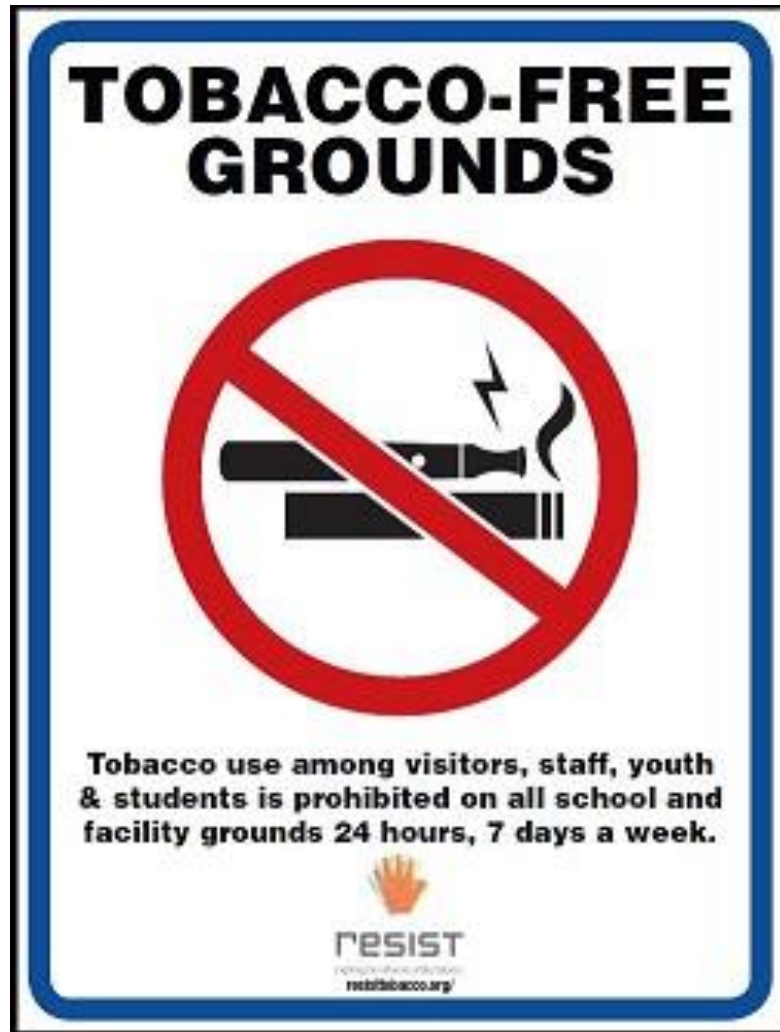
Goal Areas



Goal 1: Prevent Initiation of Tobacco Use Among Young People



Strategy 1: Increase the number of school districts & colleges/universities implementing 100% tobacco-free policies



Workplan D.1.1.1. Increase the number of schools or school districts with 100% tobacco-free policies and plan for enforcement

Workplan D.1.1.2. Increase the number of colleges/universities with 100% tobacco-free policies and plan for enforcement

Strategy 2: Increase the number of policies that restrict minors' access to tobacco products

Workplan D.1.2.1.
Increase the number of communities that adopt, strengthen and enforce policies that restrict youth access to tobacco products.



Goal 1: Prevent Initiation of Tobacco Use Among Young People



Specific Measurable Achievable Relevant and Timely

- **Example**

- **Multi-year SMART Objective:** By June 30th 2020 increase the proportion of Jones County municipalities with ordinances restricting placement of tobacco marketing advertisements from 0 to 2.
- **Annual Milestone:** By June 30th 2018 the Jones County Resist Chapters will implement a Standardized Tobacco Assessment for Retail Settings (STARS) assessment in 12 of the 12 tobacco retail establishments.

Examples of Target Populations and Target Organizations

- **Target Population:** Youth population residing in Jones County, Kansas (approximately 17,734 youth aged 13-24, per 2015 census estimate)
- **Target Organizations:** Total Tobacco Retail Establishments in Jones County Kansas (12)



Example Action Steps

1. Coordinate with Jones County School District to recruit for youth to establish Resist Chapters at both Sunshine and Starlight High Schools.
2. Work with Tobacco Free Jones County Coalition and recruit community volunteers to also participate in data collection.
3. Teach STARS assessment protocol to Resist Chapter members, Coalition Members and Volunteers.
4. Gather STARS data from all 12 tobacco retail establishments in Jones County.
5. Analyze STARS data with support from Counter Tools, Jones County Health Department Staff and community partners to evaluate final report of STARS assessment.
6. Evaluate possible policy solutions and implications based on reports with Resist Chapter members & Tobacco Free Jones County Coalition.



Example Performance Measures

- **Required:**

1. Number of youth who participate in retail-related strategies for tobacco use prevention
2. Number of policies passed that restrict youth access to tobacco products, including restrictions on flavored tobacco products, proximity of retailer to a school, or age of purchase.

- **Potential Process Measure:**

1. Number of retail establishments where a STARS assessment has been completed.



Evidence and Long-Term Impact Narrative

Checklist

- ✓ Evidence based
- ✓ Policy System or Environment Change
- ✓ Synergy with existing community initiatives
- ✓ Health Equity



Goal 1: Prevent Initiation of Tobacco Use Among Young People



- Helpful tips to consider prior to completing a Retail Workplan:
 - Determine number/sample of tobacco retailers in your community
 - Make yourself familiar with political landscape within your community
 - Determine whether or not there is interest within the youth population within your community

Goal Area 2: Eliminate nonsmokers' exposure to secondhand smoke



Strategy D.2.1: Increase policies for multi-unit housing

Workplan D.2.1.1: Increase the number of multi-unit dwellings with smoke-free policies in combination with cessation support



Strategy D.2.2: Increase the number of locations with tobacco free policies

Workplan D.2.2.1: Increase the number of tobacco-free policies in worksites, in combination with cessation and enforcement support, with a focus on low wage worksites and in locations serving low SES communities and racial and ethnic subgroups.



Strategy D.2.2: Increase the number of locations with tobacco free policies

Workplan D.2.2.2: Increase the number of tobacco-free policies in settings where people gather, e.g.: parks, trails, farmers markets, sports arenas and outdoor work areas.



Why these work plans?

Tobacco-free outdoor settings

- 2nd smoke harms everyone
- Part of national trend
- Changes community norms
- Creates a consistent tobacco free policy
- Reduces tobacco litter

Worksites

- Improves employee health
- Lowers costs
- Increases productivity & morale

D.2.2 Work Plan Example

Multi-year SMART Objective

- By June 30, 2020 increase the number of Atwood parks that are tobacco free from 0 to 6. (Atwood has 6 parks.)

Annual Milestone

- By June 30th 2018 increase the number of Atwood parks that are tobacco free from 0 to 3.

Who is the target?

Target population

Residents of Atwood County (10,000)

Target Organization

Atwood Parks & Recreation, County Commissioners
(oversees 6 parks)



Step by Step Example

1. Identify project champion within coalition to lead effort.
2. Conduct assessment of existing policies, collect & use data, gather sample policies.
3. Work with Atwood Healthy Communities Coalition to create messages to educate about the benefits of tobacco free parks. Determine most effective method of delivery to persuade & educate policy makers.



4. Engage youth volunteers to not only help deliver messages, educate community on tobacco free policies.
5. Organize a coordinated effort encouraging local health department, community agencies, & businesses to promote tobacco free parks using messages developed.
6. Meet with Atwood Parks & Recreation/County Commissioners to discuss tobacco free parks & work to draft a policy.
7. Present tobacco free parks policy to the Parks & Recreation Advisory Board.



Performance Measures

Required measure & data source

- Atwood has six parks; none are tobacco free

Data Source- Parks & Rec.

Additional Measures & Data Sources

- Conduct a baseline measure of cigarette litter in the parks.
Survey/observation



Evidence & Long-Term Impact Narrative



Doing the Homework - Tips

- Before completing a workplan to make parks tobacco-free, talk to the city about what policies are currently in place.
- Determine coalition's interest and support in tobacco free parks



Goal Area 3- Promote quitting among adults and young people: Strategies & Workplans

D.3.1: Increase the engagement of health care providers and systems to expand utilization of proven cessation services.

- Workplan D.3.1.1: Promote Adoption of the Kansas Tobacco Guideline for Behavioral Health Care by behavioral health care facilities.
- Workplan D.3.1.2: Establish tobacco dependence screening, referral and treatment systems within Federally Qualified Healthcare Centers.
- Workplan D.3.1.3: Establish tobacco cessation screening, referral and counseling systems targeting healthcare providers serving women during the perinatal period.



**Community Health Center
of Southeast Kansas**

Goal Area 3: SMART Objectives

Specific **M**easurable **A**chievable **R**elevant and **T**imely

- **Example of a Multi-year SMART Objective:**

By June 30, 2020 Increase the proportion of Saline County programs that serve pregnant women who have a system in place to train new staff on talking to patients about tobacco use and referring them to the KTQL from 17% (1 of 6) to 100% (6 of 6).

- **Example of an Annual milestone:**

By June 30, 2018 Increase the proportion of Saline County programs that serve pregnant women who have a system in place to train new staff on talking to patients about tobacco use and referring them to the KTQL from 17% (1 of 6) to 50% (3 of 6).

Goal Area 3: Target Pop and Organizations

- **Example Target Population:**

Pregnant women participating in WIC in Saline County

- **Example Target Organizations:**

Saline County Health Department, Salina Family Health Care, Pregnancy Service Center, Salina Regional Health Center, Heartland Program.



Goal Area 3: Action Steps

Example Action Steps:

1. Develop plan for implementation of the community action plan to address smoking and pregnancy based on recommendations from Saline County Smoking & Pregnancy Community Team.
2. Hold 2 A's and R Trainings for agencies that serve pregnant women
3. 4. Work with (6) target organizations to develop a system for training new staff members on talking to pregnant patients about tobacco use
5. Review and update new staff orientation packets to include completion of the Brief Tobacco Intervention on-line training.



Goal Area 3: *Evidence and Long-Term Impact* Narrative

Examples of Components to include:

- In Saline County the percent of births where the mother smoked during pregnancy as 20.8% compared to state rate of 12.7%
- Central KS Foundation created the Saline County Smoking & Pregnancy Community Team which includes commitments from Salina Family Health Care, Pregnancy Service Center, Saline County Health Department, Salina Regional Health Center, Heartland Programs, Central Kansas Foundation, and Ashby House.
- The community team reviewed evidence based strategies around smoking and pregnancy, developed a list of resources currently being done to address this issue and developed action steps to address including having all agencies staff complete BTI online training.

Goal Area 3: Performance Measures

Required Performance Measures and Data Sources (refer to RFP)

- Number of healthcare provider organizations that...(data source: organization tracking sheet)
- Number of healthcare provider organizations that... (data source: organization tracking sheet; policy tracker)
- Number of healthcare providers in target locations who...(data source: Quarterly BTI reports)
- Number of women who are currently pregnant, planning pregnancy or currently breastfeeding who enroll in the Kansas Tobacco Quitline (data source: KTQL reports)

Examples of additional performance measures:

- # of staff members from organizations serving pregnant women who attend cessation trainings (Sign-in sheet; participation tracker)
- # of contacts made with the key contact person at each of the organizations with programs that serve pregnant women (Contacts tracking sheet).
- # of fax referrals to the KTQL from Saline County organizations that serve pregnant women (fax referral tracking sheet)

Goal Area 3:TIPS

- TIPS prior to completing application:
 - Do your homework
 - Before completing a workplan to integrate tobacco dependence screening, referral and counseling into an FQHC or health department, find out what the current system is, existing policies, etc.
 - Reach out to potential partner organizations and gauge willingness to work with you prior to writing them into your workplan.
 - Prior to requesting funding for TTS training with KUMC, make sure faculty are able to meet the demand.
 - Prior to including pregnancy and smoking in workplan, know your rates of smoking in this population

Goal Area 4- Increase access to healthy foods and physical activity

- Strategy D.4.1: Increase support for policies and programs that expand access to healthy foods and opportunities for physical activity in worksite and community settings
- Strategy D.4.2: Create safe and walkable communities that are distinctive, attractive, and foster a strong sense of place
- Strategy D.4.3: Increase community resiliency

Goal Area 4- Increase access to healthy foods and physical activity

Example SMART Objective and Milestone

Workplan D.4.2.2: Adopt and/or implement/enforce master bike/walk transportation plans, master park plans, and/or master trail plans in combination with inclusive and culturally competent community engagement and awareness activities

- Multi-year SMART Objective: By June 30th 2020 increase the number of Jones County jurisdictions that have adopted a master bike/walk plan from 1 to 5.
- Annual Milestone: By June 30th 2018 the Jones County Health Department and its partners will present finalized master bike/walk plans to 2 city councils for adoption.

Goal Area 4- Increase access to healthy foods and physical activity

Example Target Populations and Organizations

- *Target Population:* People residing in the cities of Jewell, Ames, Corvallis, and Ashland in Jones County (approximately 18,548 total people, per 2015 census estimate); those living below 100% the poverty level (average of 10% of city populations, per 2015 census); Burmese refugee populations (average of 12% of city populations, per 2015 census)
- *Target Organizations:* City Councils in Jewell, Ames, Corvallis, and Ashland; County and City Planning Commissions and Departments; Kansas Department of Transportation, Burmese Refugee Network; Agency on Aging

Goal Area 4- Increase access to healthy foods and physical activity

Example Action Steps:

- Develop partnerships with the lead agency(ies) and organization(s) that are currently working on or interested in developing a master bike/walk plan (including city and county planning and transportation departments) and that represent people in the community with a vested interest in active transportation and equitable access (including the Burmese Refugee Network); identify their goals and values.
- Promote and lead community engagement efforts in the development of the plan, ensuring that diverse and underserved populations are informed of the opportunity to provide input, are actively recruited to meetings, have access to meetings, and are given reasonable accommodations (e.g. childcare, interpreter, etc.).

Goal Area 4- Increase access to healthy foods and physical activity

Example Action Steps, Continued

- Evaluate engagement and perceptions of the planning process among community and organizational stakeholders during development of the plan and adjust engagement and plan development strategies accordingly to ensure inclusion and opportunities for active participation
- Work in partnership with organizational and community stakeholders to develop and finalize the plan, ensuring inclusion of health and equity considerations (such as equitable access to sidewalks and infrastructure that connects to destinations like health care, grocery stores, and parks) and alignment with community input; present to city and/or county officials for adoption and subsequent implementation.

Goal Area 4- Increase access to healthy foods and physical activity

Additional Performance Measure Examples

- Number and type of organizations partnered with in development and adoption of master bike/walk plan
- Number of community members from target population(s) that actively participate in at least 1 planning meeting and that actively participate in at least 2 planning meetings
- Results from evaluation of community engagement by type of engagement strategy and a description of community members engaged

Goal Area 4- Increase access to healthy foods and physical activity

Evidence and Long-Term Impact Narrative

- Understand and describe the importance of adopting master bike/walk or similar plans in your local communities. What will this accomplish?
- Tie in how developing and adopting a master bike/walk or similar plan will support other long-range public health efforts in the community.
- Describe partnerships that will be built or strengthened as a result of this work and what impact that will have on public health efforts in the community.

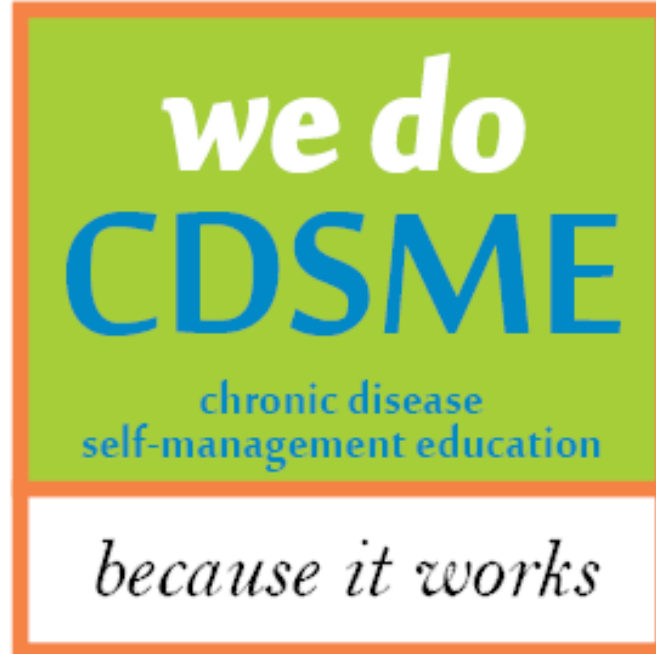
Goal Area 4- Increase access to healthy foods and physical activity- TIPS

TIPS prior to completing application

- What plans and policies are already in place your community?
- What groups or sectors are working in this area that you should coordinate and partner with? Are they willing to partner?
- What populations are most underserved in your community and where do they live, where do they work, and what issues are important to them?
- What type of evaluation or research has already been done in your community that you can use as a basis for your work (e.g. CHIP, community food assessment, Health Impact Assessment, etc.).

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

- Strategy D.5.1. Increase Access to CDSME Programming
 - D.5.1.1. Promote and coordinate the expansion of CDSME programming opportunities and their reach



CDSME Terms

Chronic Disease Terms

CDSME-broad term used for a variety of chronic-disease self-management programs. *Example-Stanford University created a suite of CDSME programs that includes CDSMP and DSMP

CDSMP-specifically Stanford's chronic disease self-management program.

Tomando Control de su Salud-Stanford's Spanish CDSMP

Diabetes Terms

DSME-broader term used for diabetes education

*Example-The DSMP workshop at the library was a great complement to the DSME that I received at my physician's office.

DSMP- specifically Stanford's diabetes self-management program

Programa de Manejo Personal de la Diabetes-Stanford's Spanish DSMP

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

Specific **M**easurable **A**chievable **R**elevant and **T**imely

- Example

- Multi-year SMART Objective:

By June 30, 2020, the number of health care providers referring patients to CDSME will increase from 0 to 2.

- Annual Milestone:

By June 30, 2018, the number of organizations delivering CDSME workshops consistently will increase from 1 to 2.

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

- **Target Population:** People in XYZ County Kansas with a chronic condition (approximately 17,734 per 2015 census estimate)
- **Target Organizations:** XYZ County Library and XYZ Senior Center (2)



Improve your health one step at a time.

**Take Charge.
Feel Better!**

KANSAS | **Chronic
Disease
Risk
Reduction**

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

Required Action Steps:

- Engage one or more organizations to commit to being delivery-system partners
 - 2 or more workshops
 - Designated CDSME Coordinator
- Provide TA to local leaders and organizations while they coordinate and implement workshops.
- Assist in marketing/promotion efforts (e.g. distribute educational materials to recruit participants, leverage earned media to recruit partner organizations and participants)
- Ensure data from workshop forms is entered into **Compass database**, assist leaders with collection of workshop forms and submission of forms to the Kansas Foundation for Medical Care.
- Work with KDHE CDSME Coordinator to identify and recruit **one or more healthcare providers** as referral partners.
- Identify **one or more persons** to attend Fidelity Check Training online or in person. This training will equip identified person(s) to visit all local leaders at one workshop per year to support them and ensure Stanford fidelity guidelines are being upheld.

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

Required Performance Measures:

- Number of organizations coordinating and implementing one or more CDSME programs consistently
- Number of community organizations referring to workshops
- Number of providers referring to workshops through a trackable referral system



Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

A strong narrative will show:

- Rationale and evidence-base for CDSME
- Sustainability of the activity over time
- Synergy with other community efforts to address chronic disease
- Impact

tell the
STORY

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)- TIPS



- Do your homework
 - Which organizations are currently holding workshops or could be holding workshops?
 - Do you have people who are trained leaders or who could become trained leaders?
- Know how the Kansas Arthritis Program can support this activity
 - Promotional items, workshop supplies, travel and training expenses
- Consider staffing needs
 - This will depend on several factors
- Call me

Goal Area 5 – Increase the ability of those with chronic disease to manage their condition(s)

Resources:

- ✓ Stanford Patient Education:
<http://patienteducation.stanford.edu/programs/cdsmp.html>
- ✓ Kansas Department of Health and Environment, Tools for Better Health: www.ToolsForBetterHealthKS.org
- ✓ Kansas Behavioral Risk Factor Surveillance System:
<http://www.kdheks.gov/brfss/>

Application Instructions

“Pick up a pen start writing!”
George Washington, Hamilton

● Application ● Archive
● Implementation ● Review

[Organization Summary](#)

CDRR

- Chronic Disease Risk Reduction Application
 - A - Administration and Management
 - B - Data and Information
 - D - Interventions to Improve Public Health
 - E - Communications and Promotions
 - F - Partnerships

Details

Plan Name

Chronic Disease Risk Reduction Application 2017-2018 (FY18)

Description

The purpose of this community grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity and nutrition.

Status

51

day(s) remaining until this application is due

0

item(s) requiring more information

N/A

Awards will be applied during the implementation phase

Submit Application

Once you submit this application to your organization's administrator (Jessica McGinnis), you will no longer be able to modify it. Please verify that you have completed the following steps (if applicable) before submitting the application:

1. Provide responses to all items
2. Attach all requested documentation
3. Enter a budget

This application will be stamped with the following information:

Your Name: Jennifer Church
Today's Date: 01/24/2017

By submitting this application, I am attesting that all of the information submitted is accurate and complete.

☐ Check this box to agree to the above statements.

Submit Application

Attachments

Add Attachment

Name	Description	File	
<div>Chronic Disease Risk Reduction Salary Worksheet</div>	Complete worksheet describing details for each proposed staff member. Directions can be found within the worksheet and in the request for proposal.	Download	<div></div>
<div>Coalition Membership Form 2018 (Implementation Phase Applicants Only)</div>	Clearly identify and provide evidence of an active and diverse community coalition.	Download	<div></div>
<div>Planning Phase Form (Planning Phase Applicants Only)</div>	List current connections with different organizations, identify existing community priorities and the groups that are working on those priorities. Provide information on types and levels of partnerships pursued.	Download	<div></div>
<div>Communications Worksheet</div>	Provide a clear, complete and detailed description of proposed communications activities.	Download	<div></div>
<div>Chronic Disease Risk Reduction Request for Proposal (RFP)</div>	The RFP provides funding & technical assistance to communities to address chronic disease risk reduction through evidence-based strategies & best practices that impact tobacco use, physical activity, nutrition & chronic disease self-management.	Download	<div></div>

Add Attachment

Page size 10

5 items in 1 pages

Budget

Add Budget Line

Export Budget

Short Description	Request	Match	Revenue
No records to display.			

Add Budget Line

Export Budget

Application Instructions

- **Required Application Fields in Catalyst:**
 - Section A – Administration and Management at “Category” level (A.1)
 - Section D – Required fields at “workplan” level
 - Complete text boxes only for workplans selected for your application
- **Coalition Membership Form**
- **Planning Phase Forms**
- **Communications Form**
- **Budget**

Please use this checklist and the scoring rubric to ensure your application is complete and meets expectations for a high quality application.

The following must be submitted as attachments in Catalyst by the application deadline:

- ☒ CDRR Coalition Members Form (implementation applicant)
or CDRR Planning Phase Form (planning applicant)
- ☒ CDRR Communications Worksheet
- ☒ CDRR Salary Worksheet
- ☒ Letter from local health department designating applicant agency (if applicable)

The following must be completed in Catalyst by the application deadline:

- ☒ **A. Administration and Management, Category A.1**
 - ☒ Community Profile
 - ☒ Statement of Need
 - ☒ Community Capacity
 - ☒ Health Equity
- ☒ **D. Interventions to Improve Public Health (for each selected work plan)**
 - ☒ Multi-year SMART Objective
 - ☒ Annual SMART Objective
 - ☒ Target Population
 - ☒ Target Organization(s)
 - ☒ Action Steps
 - ☒ Performance Measures and Data Source (Required performance measures auto-filled)
 - ☒ Evidence and Long-Term Impact

Application Instructions, Continued

A - Administration and Management

0%

Category - A.1

0%

Strategy - A.1.1

0%

Strategy - A.1.2

0%

Strategy - A.1.3

B - Data and Information

0%

Category - B.1

D - Interventions to Improve Public Health

0%

Goal Area - D.1

0%

Goal Area - D.2

0%

Goal Area - D.3

0%

Goal Area - D.4

0%

Goal Area - D.5

E - Communications and Promotions

0%

Category - E.1

F - Partnerships

0%

Category - F.1

GroupingAdministration and Management

Table of Contents

DescriptionCapacity Building and Accountability

Start Date07/01/2016End Date06/30/2017

Status0% CompleteLM LinkageThis entity does not have a Logic Model.

Assigned To

Key Partners

Ext. Grantees

Planned

Sharing[Make this a Shared Item](#)

Created ByAdministrative AccountDate Created9/28/2016 9:33:50 PM

Modified ByDate Modified

Attachments

Click the "+" sign to expand this section

Custom Fields - [Customize additional fields](#) - [Settings](#)

Community Profile

Statement of Need

Community Capacity

Healthy Equity

Application Instructions, cont.

A - Administration and Management

0%

Category - A.1

B - Data and Information

0%

Category - B.1

D - Interventions to Improve Public Health

0%

Goal Area - D.1

0%

Strategy - D.1.1

0%

Workplan - D.1.1.1

0%

Workplan - D.1.1.2

0%

Strategy - D.1.2

0%

Goal Area - D.2

0%

Goal Area - D.3

0%

0%

E - Communications and Promotions

0%

Category - E.1

F - Partnerships

0%

Category - F.1

Description

Increase the number of schools or school districts with 100% tobacco-free policies and plan for enforcement

Start Date

07/01/2016

End Date

06/30/2017

Status

0% Complete

LM Linkage

This entity does not have a Logic Model.

Assigned To

Key Partners

Ext. Grantees

Planned

Sharing

[Make this a Shared Item](#)

Created By

Administrative Account

Date Created

9/28/2016 9:33:50 PM

Modified By

Carol Cramer

Date Modified

12/13/2016 12:00:21 PM

Attachments

Click the "+" sign to expand this section

Custom Fields - [Customize additional fields](#) - [Settings](#)

Multi-year SMART Objective

Annual SMART Objective (secondary objective that contributes to multi-year objective)

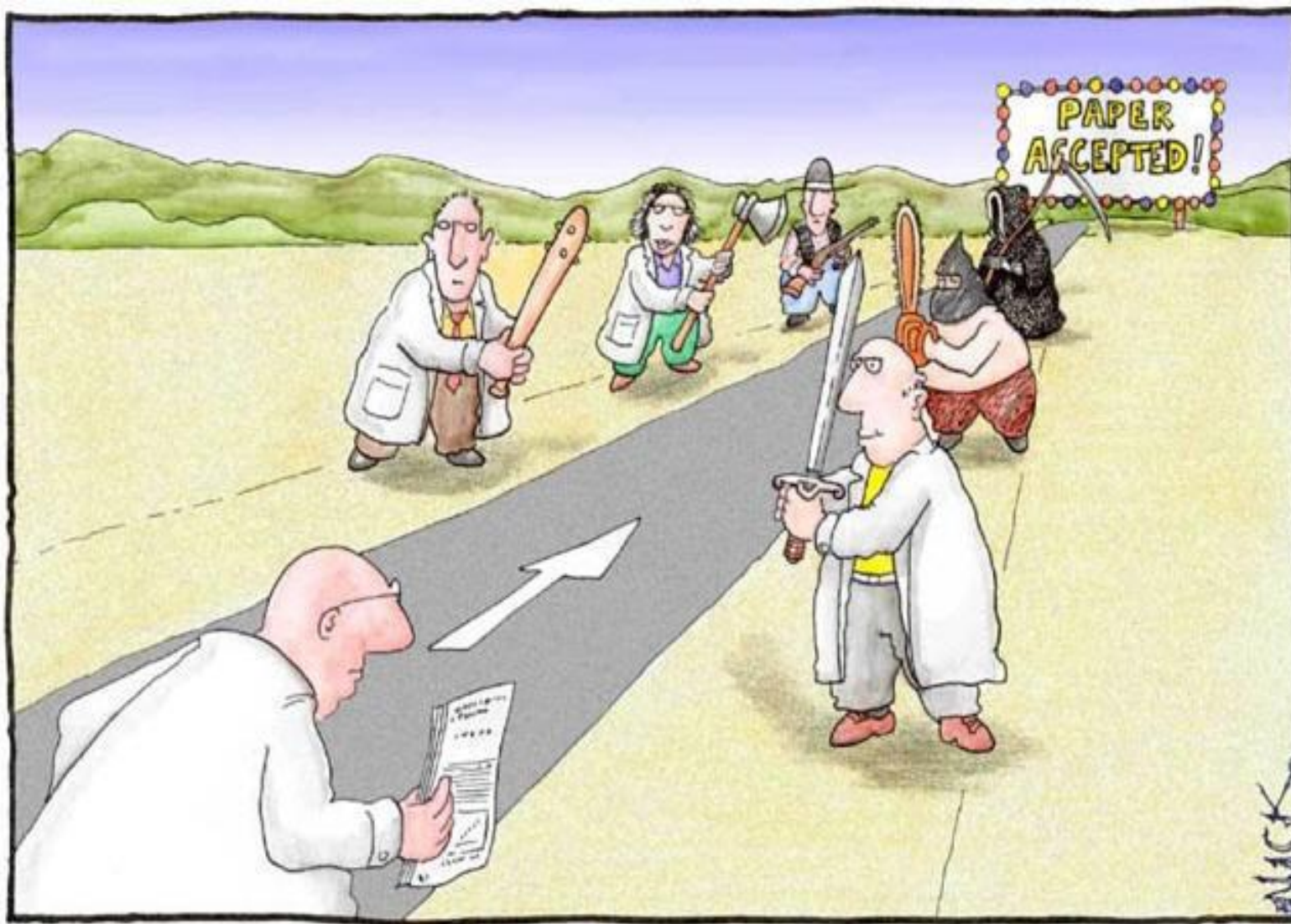
Target Population (describe and quantify)

Target Organization(s) (describe and quantify)

Action Steps (5-10 steps)

Performance Measures and Data Source

Policy, Systems and/or Environmental Impact



What forms are required?

Planning Phase Form

CHRONIC DISEASE RISK REDUCTION
PLANNING PHASE

CONNECTIONS MAP

County: _____

Please complete the following table to describe your current resources for coalition building you have with the different organizations, associations, and sectors in your community, neighbors, or acquaintances. Think about connections that may help you reach other your chronic disease risk reduction efforts. The last box can be used for any connections.

This table should be reproduced using 10-pt bold font for cell titles and 10-pt regular font as needed to capture all relevant community connections.

Corporate/Business/Labor and Employee Unions	Social Service Agencies
K-12 Schools/School Boards/PTA	Youth-led Groups/Youth Advocacy Organizations
Government (e.g. Law Enforcement, City Administration, etc)	Foundations (Local, State, National, Corporate)
Planning/Transportation/Parks & Rec.	Key Individuals/Champions
Health Care/Health Departments/Hospitals	Media

Print Form

TYPES AND LEVELS OF PARTNERSHIP

On-going partnerships. Individuals and groups with deep roots in the community, as well as those with a history of addressing long-standing and emerging community priorities. Resident associations, the faith community, well-established non-profits and community-based organizations fall within this group. Such grassroots groups have a strong understanding of a community's culture, recognized community leaders, and close ties to priority populations.

Critical juncture partnership. One that involves a short-term alliance focused on a specific purpose or task. It is important to identify partners who are strong allies who are unlikely to join the day-to-day work of the coalition, but are willing to lend a hand at critical junctures of chronic disease risk reduction efforts (e.g., when policy changes are proposed or legislative action is required).

Zones of collaboration. Collaborations with intermediary groups (e.g., community foundations) that are working to address other community priorities but serve the same populations. Zones of collaboration are no-compete, resource-sharing spaces developed by two or more organizations that are "competitors in the marketplace." Residents' groups, the faith community, service providers, schools, health coalitions, local government, and others may be "competitors" seeking to work with and serve the same population groups in the community, or "marketplace."

Type of Partnership	Names of Individuals or Organizations	Ideal Time to Partner			Strategies to Foster the Partnership
		0-12 mo	Next Year	After 1 Year	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

IDENTIFYING LINKAGES
BETWEEN COMMUNITY PRIORITIES & PHYSICAL ACTIVITY & NUTRITION

Identify existing community priorities and the groups that are working on those priorities. Recently published community reports are one source of information. However, the best information comes from talking to representatives of local groups.

Community Group/Audience	Likely Priority Issue(s)	Link to Physical Activity and Nutrition Grant Activities	Partnership Opportunities

Coalition Membership Form

Chronic Disease Risk Reduction Coalition Members Coalition Name and County: _____

Coalition Members and/or partners: By listing your name on this form you are acknowledging that you or your organization are an ACTIVE member of the coalition and/or a work group and that you contribute to progress in at least one of the following areas: tobacco prevention and control, physical activity/nutrition (PAN) promotion, or worksite wellness (WW). If not affiliated with an organization simply list your name.

Main social institutions representation:

Sector	Organization Name	Town represented in the county	Tobacco / PAN / WW	Name
K-12 Schools				
Faith Community				
Business				
Government *				
Media				
Health Agency				

* Could be law enforcement, city administrator, etc. If working on Physical Activity and Nutrition, must include planning/transportation representation.

-continued-

List other **common community organizations** represented on your coalition such as clinics, hospitals, universities/colleges, day care centers, ethnic associations, housing authorities, libraries, neighborhood groups, parent organizations, recreational groups, service associations, social service agencies, veterans' groups.

Sector	Organization Name	Town represented in the county	Tobacco / PAN / WW	Name

List representation from **specialized groups** who are oriented around issues central to your mission. This may include organizations or individuals representing mental health, substance use disorders, tobacco, etc.

Sector	Organization Name	Town represented in the county	Tobacco / PAN / WW	Name

Do you have direct **youth representation** or a affiliation with a youth group?

Youth under 18	Youth Organization/Group	Town represented in the county	Tobacco / PAN / WW	Name

Look at your county demographics. Does your coalition reflect your community make up? Indicate underserved population groups which are represented.

- | | |
|--|---|
| <input type="checkbox"/> Racial/ethnic minorities | <input type="checkbox"/> People living in rural communities |
| <input type="checkbox"/> People with less than a high school education | <input type="checkbox"/> People who identify as LGBT |
| <input type="checkbox"/> People with low income | <input type="checkbox"/> Older adults |
| <input type="checkbox"/> People with disabilities | |

Sources:

Community Tool Box, Chapter 7, Section 2: Working Participation Among Diverse Groups. <http://ctb.ku.edu/article-of-content/participation/engaging-members/different-participation.htm>

CDC National Center for Chronic Disease Prevention and Health Promotion, Division of Community Health: A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. <http://www.cdc.gov/nccdp/health-equity-guide/>

Communication Form

Chronic Disease Risk Reduction – Communications Worksheet

Coalition Name and County: _____

Check the two months you plan to mail letters to each of your state legislators:

☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec. ☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June

For each selected work plan, briefly describe the following information:

Work Plan: _____

KS Tobacco Quitline materials (<u>tobacco work plans only</u>)	Planned paid media	Activities to capitalize on local interventions, national reports/data releases and current events to generate earned media

Specific members of the public or groups targeted	Planned public relations activities	Social media activities

Salary Worksheet

Please complete salary spreadsheet & enter information in blue highlighted columns. Brown shaded fields will automatically populate based on information entered.

Chronic Disease Risk Reduction Salary Worksheet

Local Agency Name:

	Employee Name	Position Title	Total Hours Worked Per Week	Percent of Time Spent on CDRR Grant per Week	Total Hours Worked Per Week on CDRR Grant	Total Salary	CDRR Total Funded Salary	Percent of grant time allocated to Tobacco Use Prevention	Percent of grant time allocated to Physical Activity & Nutrition	Percent of grant time allocated to Chronic Disease Self-Management
Example	Example - Jane Doe	Coordinator	40	50%	20	\$50,000.00	\$25,000.00	50%	40%	10%
								\$12,500.00	\$10,000.00	\$2,500.00
1			0	0%	0	\$0.00	\$0.00	0%	0%	0%
								\$0.00	\$0.00	\$0.00
2			0	0%	0	\$0.00	\$0.00	0%	0%	0%
								\$0.00	\$0.00	\$0.00
3			0	0%	0	\$0.00	\$0.00	0%	0%	0%
								\$0.00	\$0.00	\$0.00
4			0	0%	0	\$0.00	\$0.00	0%	0%	0%
								\$0.00	\$0.00	\$0.00

3. Complete this section.

4. Evaluate according to criteria and descriptors. Then ask someone to proofread.

5. Complete the forms.

1. Determine potential. Consider strategic planning.

2. Review and finalize. Less can be more.

SFY 18 (2017-2018) CDRR Scoring Guidance		
Administration and Management: Evidence that the organization has a need for and ability to successfully use the funds.		Score Weight
Community Profile	Clear and specific description of community that includes data on community demographics and the prevalence of behaviors and/or chronic diseases.	40%
Statement of Need	Clear and full explanation of how the funds will benefit the community through the selected work plans.	
Community Capacity	Staff, partnership collaboration, resources, and necessary training and tools are detailed and linked specifically to addressing community needs.	
Health Equity	Advancement of health equity is completely addressed, details a comprehensive plan for engaging underserved populations, and it appears likely the applicant will moderately advance health equity.	
Budget & Salary Worksheets	Detailed and realistic budget with clear justification of proposed expenditures for carrying out selected work plans.	
Communications and Promotions: Evidence that the organization has a plan for effectively communicating with the public and legislators.		
Communications Worksheet	Clear and detailed description of proposed communications activities and full completion of communications worksheet.	10%
Community Engagement: Evidence that the organization actively engages diverse community stakeholders and underserved populations.		
CDRR Coalition Member Form	Clearly identifies and provides evidence of active representation from diverse community stakeholders and sectors on community coalition.	5%
Application Quality: Evidence that the organization applied forethought, organization, and correct grammar to their application.		
Grammar and Content Organization	Exemplary grammar and content organization that is easy to read and comprehend, and has no or few minor errors.	5%
Completion and Conciseness	Provides complete and concise responses.	
Work Plans to Improve Public Health		
Annual and Multi-Year SMART Objectives	Annual and multi-year objectives are SMART, realistic and achievable, and are likely to advance health equity.	40%
Action Steps	Action steps are logical, appear likely to lead to significant progress toward annual and multi-year SMART objectives, include actions to address health equity, and show coordination with partners.	
Performance Measures and Data Sources	Required performance measures are included. Additional performance measures are included, clear, and very likely to demonstrate progress. Data sources are included for all performance measures and are clearly described and appropriate.	
Evidence and Long-term Impact	Work plan is evidence based, linked to sustainable policy, systems or environmental changes, shows synergy with other work in the community, and appears very likely to produce significant long term positive impact	
The total points from each workplan will be averaged.		

Who are the underserved? How can I engage them? Remove barriers & incentivize participation.

Approximately **6 weeks** to deadline – **Wed. Mar. 15**

Friday, Mar. 10 – Enter into Catalyst. Request CHS to check application completeness.

Week of Mar. 6-10 – Complete forms. Double check everything.

Week of Feb. 27-Mar. 3 – Self-evaluate writing. Ask for feedback. Begin forms.

Week of Feb. 20-24 – Complete Administration & Management section.

Week of Feb. 13-17 – Finalize selected work plans. Ask stakeholders to review.

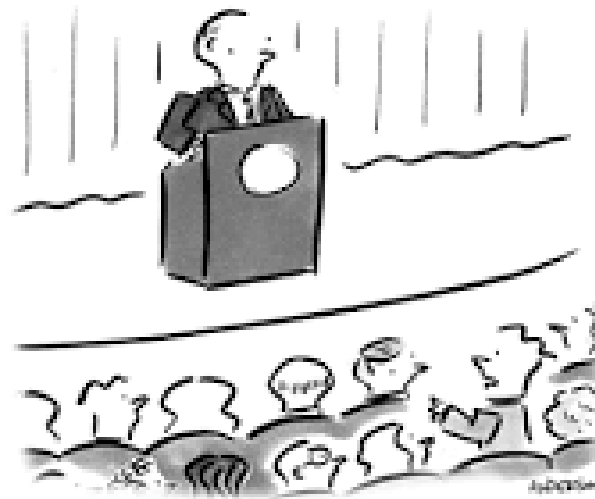
Week of Feb. 6-10 – Strategic planning sessions, (with stakeholders).

Week of Jan. 30-Feb. 3 – Determine potential work plans. Set up strategic planning sessions.

Q and A Period

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"Yes, I'd like to ask a very specific question
that pertains only to me, and then go
on and on and on..."